| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

## Filing at a Glance

Company: The Union Labor Life Insurance Company

| | | |
|---|---|---|
| Product Name: ULLGA-TL-0302 1011 | SERFF Tr Num: ULCC-127758909 | State: Arkansas |
| TOI: L04G Group Life - Term | SERFF Status: Closed-Approved | State Tr Num: 50099 |
| Sub-TOI: L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life | Co Tr Num: | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Donna Lambert, Linda Bird |
| | Authors: Kevin Ross, Carla Wallace | Disposition Date: 10/28/2011 |
| | Date Submitted: 10/25/2011 | Disposition Status: Approved |
| Implementation Date Requested: On Approval | | Implementation Date: 11/28/2011 |
| State Filing Description: | | |

## General Information

| | |
|---|---|
| Project Name: Group Term Life Insurance Application | Status of Filing in Domicile: |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: |
| Submission Type: New Submission | Overall Rate Impact: |
| Filing Status Changed: 10/28/2011 | |
| State Status Changed: 10/28/2011 | Deemer Date: |
| Created By: Carla Wallace | Submitted By: Carla Wallace |
| Corresponding Filing Tracking Number: | |

Filing Description:

RE: Group Life Insurance Application, form ULLGA-TL-0302 1011
The Union Labor Life Insurance Company
NAIC 781-69744 FEIN 13-1423090

Dear Sir or Madam:

Attached for your review and approval is the Group Life Insurance Application form ULLGA-TL-0302 1011.

This form is new and it will not replace any existing form. This form will be used in connection with our various approved

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

Group Term Life Insurance products.

This form is in final print. Also attached is a Variable Memorandum explaining how this form may be modified to accommodate the products being marketed with this application.

If you have questions regarding this filing, Please feel free to contact me directly with any questions.

Thank you,

Carla W. Wallace, MA
Senior Compliance Analyst
Policy Development Department

SOLUTIONS FOR THE UNION WORKPLACE

8403 Colesville Road
Silver Spring, MD 20910
202.962.2901 phone
202.682.6713 fax
cwallace@ullico.com
www.ullico.com

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Carla Wallace, Compliance Analyst | cwallace@ullico.com |
| 8403 Colesville Rd | 202-962-2901 [Phone] |
| Silver Spring, MD 20910 | |

**Filing Company Information**

| | | |
|---|---|---|
| The Union Labor Life Insurance Company | CoCode: 69744 | State of Domicile: Maryland |
| 8403 Colesville Road | Group Code: 781 | Company Type: Life and Heallth |
| Silver Spring, MD 20910 | Group Name: | State ID Number: |
| (202) 682-0900 ext. [Phone] | FEIN Number: 13-1423090 | |

---

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $125.00 |
| Retaliatory? | No |
| Fee Explanation: | 1 form @ $125.00 = $125.00 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| The Union Labor Life Insurance Company | $125.00 | 10/25/2011 | 53152401 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Donna Lambert | 10/28/2011 | 10/28/2011 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

# Disposition

Disposition Date: 10/28/2011
Implementation Date: 11/28/2011
Status: Approved
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved | Yes |
| **Supporting Document** | Application | Approved | Yes |
| **Supporting Document** | Variable Memorandum | Approved | Yes |
| **Form** | Group Life Insurance Application | Approved | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

# Form Schedule

**Lead Form Number:**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved 10/28/2011 | ULLGA-TL-0302-1011 | Application/ Enrollment Form | Group Life Insurance Application | Initial | | 50.100 | Group Life Insurance Application ULLGA-TL-0302-1011.pdf |

**[ LIFE INSURANCE APPLICATION**
**THE UNION LABOR LIFE INSURANCE COMPANY**
**Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006 ]**

[ John Q. Sample
Street Road
Second Address Line
Anytown, US 00000 ]

[ Member of:
International Union Personalized ]

## 1. Please tell us about yourself [and your spouse (if applying) ]:

[Your Name John Doe ]
[Address 123 ABC Lane ]
[Address Unit 7654 ]
[City, State, Zip Capris, IA 73259 ]
Date of Birth
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐☐☐☐☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐☐☐☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

International Union Name _____ Local #_____

Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $_____

Household Income $ _____

Net Worth $_____

[Spouse* Name Jane Doe ]
[Address 123 ABC Lane ]
[Address Unit 7654 ]
[City, State, Zip Capris, IA 73259 ]
Date of Birth
MONTH DAY YEAR
☐Male ☐ Female

State of Birth: ☐☐

Phone ☐☐☐☐☐☐☐☐☐☐
AREA CODE

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Social Security # ☐☐☐☐☐☐☐☐☐
Driver's License# _____ State of Issue ☐☐

E-Mail Address _____
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails

International Union Name _____ Local #_____

Currently employed? ☐Yes ☐No

Employer_____

Length of Employment_____

Occupation _____

Duties _____

Employer Address_____
(street, city, state, zip)

Personal Earned Income $ _____

Household Income $_____

Net Worth $ _____

***Spouse includes Domestic Partner, Civil Union Partner, or Legal Partner as recognized by the jurisdiction in which you reside.** ]

## 2. Please select the benefits you [and your spouse (if applying)] would like:

| You: | [Spouse: |
|---|---|
| Choose One Product and One Coverage Amount Below:<br>Product:<br>[ ☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]<br>Coverage Amount:<br>[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000<br>☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]<br><br>Please check any additional coverage that you would like:<br><br>[☐ Accidental Death Rider: Coverage Amount: _____<br>☐ Hospital Accident Rider: Coverage Amount: _____<br>☐ Waiver of Premium Rider<br>☐ Return of Premium Rider (20 Year Term only)]<br><br>☐ Children's Term Life coverage:<br>Coverage amount: _____<br><br>List name(s) and date(s) of birth in the section below:<br>Name_____ Date of birth ☐☐☐<br>Name_____ Date of birth ☐☐☐<br>Use a separate sheet of paper if more space is needed.] | [Choose One Product and One Coverage Amount Below:<br>Product:<br>[☐ 10 Year Term ☐ 20 Year Term ☐ Other _____]<br>Coverage Amount:<br>[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000<br>☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]<br><br>Please check any additional coverage that you would like:<br><br>[☐ Accidental Death Rider: Coverage Amount: _____<br>☐ Hospital Accident Rider: Coverage Amount:_____<br>☐ Waiver of Premium Rider<br>☐ Return of Premium Rider (20 Year Term only)]<br><br>☐ Children's Term Life coverage:<br>Coverage amount: _____<br><br>List name(s) and date(s) of birth in the section below:<br>Name_____ Date of birth ☐☐☐<br>Name_____ Date of birth ☐☐☐<br>Use a separate sheet of paper if more space is needed.] |

| | |
|---|---|
| Will this insurance replace or change any life insurance or annuity contract? If yes, provide details below.<br>☐ Yes ☐ No | [Will this insurance replace or change any life insurance or annuity contract? If yes, provide details below.<br>☐ Yes ☐ No |
| Please complete the beneficiary information: | Please complete the beneficiary information: |
| Your Beneficiary: _____Relationship_____ | Your Beneficiary: _____Relationship_____ |
| Address: | Address: |
| City, State, Zip | City, State, Zip |
| Social Security Number | Social Security Number ] |

## 3. Please answer the following questions for you [and your spouse (if applying)]:

| You | [Spouse |
|---|---|
| Height _____ FEET/INCHES Weight _____ LBS. | [Height _____ FEET/INCHES Weight _____ LBS.] |

| | **You** | **[Spouse** |
|---|---|---|
| 1. Have you been cited for driving under the influence of alcohol or drugs in the past 12 months? | ☐Yes ☐ No | [ ☐Yes ☐ No |
| [2. Have you had your driver's license suspended or revoked for any reason in the past 3 years?] | ☐Yes ☐ No | ☐Yes ☐ No |
| 3. Have you had a heart attack or stroke within the past 6 months, been diagnosed or treated for cancer (other than skin cancer) within the past 2 years, or ever tested positive for HIV (Human Immunodeficiency Virus) infection? | ☐Yes ☐ No | ☐Yes ☐ No |
| [4. In the past 5 years, has a medical professional diagnosed you with, treated you for, or told you to seek treatment because of: disease or disorder of the heart (including high blood pressure), blood or circulatory system, lungs, liver, bowel or kidneys, diabetes, stroke or cancer, mental or nervous disorders, or told you to reduce or discontinue use of any drug or alcohol? | ☐Yes ☐ No | ☐Yes ☐ No |
| 5. Other than those conditions covered above, do you have any chronic illnesses or conditions which require periodic medical care or may require future surgery? | ☐Yes ☐ No | ☐Yes ☐ No |
| 6. Within the past six weeks, have you been prescribed or taken any prescription medications?] | ☐Yes ☐ No | ☐Yes ☐ No] |

| | |
|---|---|
| [7. Have you used any tobacco or nicotine based products in the past 12 months?] | ☐ Yes ☐ No [☐ Yes ☐ No] |

**If you answered "Yes" to any of the above questions, please provide as much detail as possible in the space below. Identify the question number, and include diagnoses, dates, durations, names and addresses of all attending physicians and medical facilities;** ***Example: Q #3, Stroke, 5/23/2006, Dr. James Smith, 123 Any Road, City, ST, Zip, (111) 111-1111***. **Attach a separate sheet if needed.**

_____

_____

_____

## 4. Read, Sign and Date below.

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete. I understand that a separate Certificate will be issued to each applicant and that no insurance is in effect until I am issued my Certificate and my first premium is paid before my effective date and during my lifetime. I understand that if I fail to give true and complete answers on this application, benefits may be denied. If any condition affecting my insurability as stated in this application changes between my application date and my Certificate Effective Date, I understand that benefits may be denied during the first 2 years of coverage.

[To determine my insurability, or for claims purposes, I authorize any physician, medical practitioner, institution, VA Hospital, or other medically related facility, insurance company, the Medical Information Bureau (MIB), or any Consumer Reporting Agency to give any information about my physical or mental health to the Company or its reinsurers. This authorization or its photocopy is valid for 24 months from the application date and I or my beneficiary may request a copy. I may revoke this Authorization at any time by submitting a written revocation request to the Company, but the revocation will not affect actions taken before receipt of the revocation or any legal right the Company has to contest my certificate or a claim under my certificate based on information obtained prior to the revocation. I have read the applicable fraud notice on this application and the Notice to Applicant enclosed with this form as required by the Fair Credit Reporting Act.]

[ **For Residents of California**: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For Residents of Colorado**: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**For Residents of District of Columbia**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**For Residents of Florida**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For Residents of Louisiana**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of Maryland**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[**For Residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For Residents of Rhode Island**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of Washington**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits. ]

**Information Practices Notice**

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in Our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer.

**[Information Regarding the Medical Information Bureau Pre-Notice**

Information regarding your insurability will be treated as confidential. The Union Labor Life Insurance Company or its reinsurers may; however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Union Labor Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at http://www.mib.com.

| | |
|---|---|
| X _____ | X _____ |
| Your Signature Date | Spouse Signature Date ] |

**[Agent Certification**

I certify that: (1) the application was obtained personally and in my presence; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; (3) to the best of my knowledge, this policy will ☐ will not ☐ replace or change any existing life insurance or annuity policy(ies); and (4) I have witnessed the signature(s) on this application.

| Licensed Agent's Signature | Agent's Printed Name | Agent's Number |
|---|---|---|

| Telephone Number | Date |
|---|---|

State License # _____ Email _____

**Mail Certificate To: ☐ Owner ☐ Agent]**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-127758909* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *50099* |
| *Company Tracking Number:* | | | |
| *TOI:* | *L04G Group Life - Term* | *Sub-TOI:* | *L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* |
| *Product Name:* | *ULLGA-TL-0302 1011* | | |
| *Project Name/Number:* | *Group Term Life Insurance Application/* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved | 10/28/2011 |

**Comments:**
Document Attached.
**Attachment:**
Readability Certification.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Application | Approved | 10/28/2011 |

**Bypass Reason:** This section is not applicable.
**Comments:**

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Variable Memorandum | Approved | 10/28/2011 |

**Comments:**
Document Attached.
**Attachment:**
Variable Memorandum for Group Life Insurance Application ULLGA-TL-0302-1011.pdf

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**Administrative Office: 8403 Colesville Road, Silver Spring, Maryland 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006**

## READABILITY CERTIFICATION

I certify that the form submitted with this filing achieved the following score using the Flesch Test Reading Score standards.

| Form | Description | Score |
|---|---|---|
| ULLGA-TL-0302 1011 | Group Worksite Application Form | 50.1 |

**Stephanie Whalen,**
**VP Life and Health Operations**